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Original Article

A concept analysis of cultural competence



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ABSTRACT

Objectives: To clarify the meaning and reduce ambiguities of the concept cultural competence, and promote consistency in using the concept in nursing dialog, research, and practice.

Method: Using Walker and Avant's method of concept analysis.

Results: Cultural competence is the gradually developed capacity of nurses to provide safe and quality healthcare to clients of different cultural backgrounds. Its defining attributes are cultural awareness, cultural sensitivity, cultural knowledge, cultural skill, and dynamic process. Antecedents are cultural diversity, cultural encounter, and cultural desire. Consequences involve three beneficiaries, as follows: clients, nurses, and healthcare organizations. Empirical referents are primarily consisted in self-reported tools.

Conclusions: The understanding of cultural competence of nurses that emerged in this concept analysis will contribute to the development of a rigorous design of instruments or research.

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1. Introduction

With the integration of global economy, the number of clients from various cultural backgrounds with different health related attributes, cultural practices, healthcare needs, and expectations increased in all the industrialized countries. Therefore, cultural competence, which is the ability to respond to cultural diversity inside healthcare systems, is highly expected [1]. Nurses, who form the largest groups of healthcare workforce and who work in most locations where healthcare is provided, must possess cultural competence to ensure safe and quality nursing service.

However, the meaning of cultural competence is ambiguous in the literature [2,3]. The terms “culture” and

“competence”, which are derived from the concept, are complex ideas without consensus on either term. Inconsistencies and debates exist on the conceptual understanding of cultural competence in the literature. The terminologies in this area, including cultural competence, cultural safety, cross-cultural competence, or transcultural nursing, are also used interchangeably or as personal preference because of the lack of clear definitions [2].

In pursuing culturally competent care, difficulties were recognized and experienced by clinicians and researchers in healthcare systems [4,5]. For example, when a research tool is designed to evaluate current practice or when strategies are planned, the ambiguous understanding of cultural competence acts as the main barrier in achieving culturally

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competent care. Thus, further clarification of cultural competence is essential for related nursing dialog, research, and practice. This concept analysis aimed to clarify the definition of cultural competence to help develop future research tools and improve communication in this area.

2. Method

English articles from 2000 to 2015 were searched through CINAHL, Medline, and EBSCO databases using “cultural competence” or “culturally competent care” and “nursing” as keywords. Disciplines, including nursing, medicine, education, psychology, sociology, and other related fields were examined. Relevant references were included. Articles were selected according to whether the concept of cultural competence was defined or described and whether dimensions of cultural competence were discussed. Key works from reference lists of selected articles were also included. For particularly eloquent authors, a maximum of two papers from each author was set to avoid excessive personal influence. A total of 45 articles were used for this concept analysis.

The eight-step method proposed by Walker and Avant, which requires researchers to “select a concept, determine the aims of analysis, identify uses of the concept, determine the defining attributes, identify model case, identify additional cases, identify antecedents and consequences, and define empirical referents” (p.65) [6], was used in this paper.

3. Results

3.1. The origin of the concept

Although the term cultural competence was first mentioned in the article by Cross and her colleagues in 1989 [7], Dr. Madeleine Leininger, a nurse theorist, was the first individual to coin this term. She proposed the anthropological concept of culture in nursing in her book, *Nursing and Anthropology: Two Worlds to Blend*, and rendered culturally congruent care, which was the original term of culturally competent care [8].

“Cultural” is the adjectival of culture, referring to things related to culture. Culture is a specific individual or group’s beliefs, values, norms, and lifeways that can be shared, learned, and transmitted; it influences people’s thinking, decisions, and behaviors in their everyday life [1]. The culture of clients involves far more than ethnicity or race. Determinants, such as age, gender, education, religion, socioeconomic status, geographic region, and occupation, should also be considered [9,10]. The term “competence” is an individual’s ability to perform a job [11]. In nursing, competence can be defined as the level of performance embodied in effective application of attitudes, knowledge, skills, and judgments [12].

Applications and discussions associated with cultural competence are noted throughout the literature in nursing, medicine, education, social services, and psychology. Cultural competence originated from the healthcare industry because healthcare delivery without cultural competence would directly influence health outcomes, which may lead to fatal consequences [13]. Therefore, most definitions of cultural

competence are more or less related to nursing or medicine. In nursing, cultural competence has been studied since the late 1980s as cultural diversity among the American population became a crucial concern.

3.2. Uses of the concept

Cultural competence was first officially described as a set of congruent attitudes, knowledge and behaviors of professionals that enables effective work in cross-cultural situations [7]. The Office of Minority Health in America included the words “policies,” “system,” and “agency” to understand cultural competence and described it as a set of congruent attitudes and behaviors of individual professionals and policies inside a system or agency that facilitates effective work in cross-cultural situations [14]. With this definition, cultural competence is an umbrella term that involves individual-level concerns of attitudes or behaviors, as well as organizational or systemic-level concerns of policies or procedures.

Some authors also described cultural competence as “the ability” of healthcare professionals to provide legitimate, effective and respectful service to people based on the understanding of similarities and differences between or among diverse cultural groups [1,4,15]. This ability requires the operationalization of detailed knowledge and awareness to be integrated into appropriate interventions that address healthcare problems experienced by culturally diverse populations. With this ability, healthcare professionals can emphasize the cultural background and experience of each client. Thus, each client would be treated as a unique individual to achieve client-centered and satisfactory service.

Furthermore, cultural competence is depicted as an “ongoing process” of healthcare professionals to prepare themselves with specific awareness, knowledge and skills to work effectively with diverse cultural groups [16–18]. This process can be understood as a life-long learning journey through consistent encounters with diverse clients in practice. Learnings can be implemented in healthcare delivery to optimally meet health-related demands. The National Center for Cultural Competence in America pointed out that for individual professionals and organizations, this process is a non-linear continuum that involves levels from cultural destructiveness, incapacity, blindness, pre-competence, competence, to proficiency [19]. Thus, cultural competence is a dynamic rather than a static destination.

The definitions in the literature verified that cultural competence is difficult to define in simple terms. The importance of cultural competence for nurses was highlighted in this concept analysis. Cultural competence was therefore defined as the gradually developed capacity of nurses to provide safe and quality healthcare to clients with different cultural backgrounds. As discussed above, cultural background in this tentative definition is determined by variants, such as age, gender, race, ethnicity, religion, education, socioeconomic status, geographic region, and occupation [9,10].

3.3. Related concepts

Related concepts are terms that are similar to cultural competence but with subtle differences under close examination [6].

Based on the literature, related concepts for cultural competence that are most commonly mentioned include cultural safety, cross-cultural competence, and transcultural nursing.

Cultural safety means a safe healthcare environment and the absence of discrimination; thus, both healthcare providers and clients are respected and involved in decision making in a healthcare service [20]. Cultural safety is within the concept of cultural competence and plays as a fundamental role [21]. Likewise, terms, such as cultural sensitivity and cultural awareness are actually components of cultural competence [16,18].

Cross-cultural competence was defined as an individual's ability to function effectively in another culture [22]. It usually involves comparing or contrasting two or more cultures. Cultural difference may be recognized or understood. However, only limited learning or exchange between cultural groups can be achieved. Cross-cultural competence facilitates the development of cultural competence [23].

Transcultural nursing is a broader field. Leininger and McFarland defined transcultural nursing as “a discipline of study and practice focused on comparative culture care differences and similarities among and between cultures in order to assist human beings to attain and maintain meaningful and therapeutic health practices that are culturally based” (p.16) [1]. Cultural competence is a concept that is included in transcultural nursing, which encompasses a set of concepts for cultural care. Therefore, to avoid confusion the two terms should not be used interchangeably.

3.4. Defining attributes

Defining attributes is an effort to identify characteristics that are most frequently associated with the concept and differentiate that concept from other similar or related concepts [6]. Cultural competence has five defining attributes that should be demonstrated by nurses during healthcare delivery. These attributes are cultural awareness, cultural sensitivity, cultural knowledge, cultural skill, and dynamic process.

Cultural awareness refers to the development of the consciousness of nurses of the different values, beliefs, norms, and lifeways of clients [1]. Cultural similarities and differences among clients should be recognized, and the influence of culture to health should be valued in the provision of nursing care [24]. The culture and personal stereotypes, biases, or assumptions of nurses towards other cultures that are perceived to be different should be explored [9,10,16]. Nurses only can better understand the values, beliefs, and practices of other cultural groups if they are aware of their own cultural values, beliefs and practices.

Cultural sensitivity refers to nurses' appreciation, respect, and comfort to the cultural diversity of clients. The culture of every individual cannot be assumed to be the same, and cultural diversity is inevitable. This diversity should be appreciated to achieve mutual learning for common progress. Moreover, the idea that one's own culture is superior to another's should be avoided [9,25]. Respect to cultural differences is always essential to provide genuine and satisfactory care for clients [24,26]. Both appreciation and respect are based on feeling comfortable within this cultural diversity instead of false flattery to other cultures [10,24].

Cultural knowledge refers to nurses' attainment of a sound educational base about various cultural groups to better understand different beliefs, values, and behavior of clients. Necessary knowledge usually involves “dos” and “don'ts” in interacting with clients from different cultures [27], and these activities are related to diet, communication, and other etiquettes. With these principles, unintended cultural offenses can be prevented and trust from clients can be established [26]. However, the knowledge that one can prepare himself or herself before encounters with clients is the main culture [27]. The information of subcultures with all subtle nuances, which helps avoid cultural conflicts and provides sensitive care to individuals, should be obtained from actual encounters. Nurses should be familiar with the concepts, theories, or models related to the provision of service to culturally diverse groups [24], which would help identify healthcare needs and appropriate nursing options.

Cultural skill refers to the ability to perform cultural assessment to collect relevant cultural data of a client's current health problem, as well as to accurately incorporate related data into care planning and provision in a culturally sensitive manner [1,10,28]. This skill is guaranteed through effective communication, which includes both verbal and nonverbal language that can be understood by those of other cultures [24]. The appropriate use of interpreters is sometimes essential to achieve mutual understanding [29]. Moreover, available, factually reliable, and culturally appropriate resources should be obtained to plan and provide satisfactory, safe, and beneficial care services for culturally diverse populations [30].

Dynamic process is also one of important attributes of cultural competence, which is reiterated in the literature [10,16,25]. Dynamic process means nurses are “becoming culturally competent rather than being culturally competent” (p.42) [16] through consistent encounters with diverse clients. Culture, which is influenced by many variants, has a dynamic nature [10]; thus, cultural competence cannot be a static situation. People express their emotions, manifest their sufferings, and interpret their symptoms and concerns variably because of cultural differences. Nurses cannot be assumed to have sufficient knowledge and skills to provide service that is culturally consistent with every client [10,27]. Therefore, cultural competence can be gradually developed through ongoing efforts to provide care according to clients' cultural context. Nurses can only learn from diverse cultural groups to be culturally proficient in healthcare delivery through this approach.

3.5. Model case

A model case is a real-life example of the concept that demonstrates all of its essential attributes [6]. For example, Ms. Wang is a Chinese registered nurse working in endocrinology unit in one Chinese university hospital. An American Christian client with type 2 diabetes was admitted at her shift. Ms. Wang can speak English and is aware of the client's different cultural background. Besides from conducting the routine procedure, she consulted the client about his preferred diet and shower time. She discussed with a nutritionist to prepare the proper meals and informed a nursing assistant to help the

client take shower in the morning instead of evening. She informed her colleagues and other clients in the same room about the client's cultural belief and different cultural related habits and instructed them on how they could show respect towards this client. Using traditional Chinese medication is common choice for Chinese clients. Thus, Ms. Wang conveyed information to the client and consulted him about his choice. Substantial professional information must be informed to the client. Thus, Ms. Wang asked a nursing instructor who is good in English to act as an interpreter and communicate with the client if necessary. During the course of providing nursing care, Ms. Wang learned more about the client's Christian belief, western style diet, and living habits from both the client and the Internet. On the day that the client was to be discharged, Ms. Wang provided the client with a specific list containing suggestions on diet and exercise based on the client's dietary, cooking, and other living habits.

In this case, Ms. Wang developed from having cultural awareness to having cultural competence in taking care of the client. During the entire process, Ms. Wang demonstrated cultural awareness, sensitivity, knowledge, and skill to be a culturally competent nurse.

3.6. Additional cases

A borderline case demonstrates some but not all defining attributes. As the model case, Ms. Li, a Chinese registered nurse, was taking care of an American Christian client with type 2 diabetes. Ms. Li could not understand and speak English. During the course of providing nursing care, Ms. Li usually used body language and pictures to communicate with client. She took care of the client just as Ms. Wang did. However, every time the client had professional questions, Ms. Li just smiled to show politeness. Therefore, the client stopped asking questions. On the third day of admission, the client asked to be transferred to a foreign unit to continue treatment. In this case, Ms. Li exhibited cultural awareness, respect, and some cultural knowledge related to this client, but she did not have the cultural skill to provide nursing care based on the client's cultural context. Thus, the dynamic process was also cut off.

The opposite case does not demonstrate cultural competence because it lacks all the defining attributes. In another case, a Chinese registered nurse, Ms. Sun, was also taking care of an American Christian client with type 2 diabetes. Without asking the client's preference, Chinese fast food was served. When the client planned to take shower, the shower room was locked in the morning. Therefore, this nurse did not exhibit any characteristic that is required for a culturally competent nurse.

3.7. Antecedents and consequences

Antecedents are events that must occur before the occurrence of the concept [6]. For cultural competence, **cultural diversity** is identified as one essential antecedent through a literature review [1]. The increasing cultural diversity in the healthcare system around the world highlighted the need to enhance cultural competence among nurses. Cultural diversity can be understood as the differences in color, race, national origin,

ethnicity, socioeconomic status, education, occupation, religion, and other related characteristics of groups of people [9,10]. Cultural diversity among clients who have various healthcare attributes and expectations directly require nurses to exhibit cultural competence [1,17].

Cultural encounter is the interaction between nurses and clients of different cultures, which is also identified as one antecedent. The interaction can be face-to-face or indirect via different forms of communication [24]. Continuous encounters provide opportunities for nurses to learn from different cultural groups and help nurses refine their former beliefs and avoid stereotyping [24]. Therefore, cultural encounters are necessary for nurses to be culturally competent. **Cultural desire**, which is another antecedent that is motivated by cultural encounters, can be described as wanting to be culturally competent, but not having to be culturally competent. The desire to be exposed to clients with different cultural backgrounds facilitates the process of becoming culturally competent [16].

Consequences are events that are caused by the occurrence of a concept [6]; recognizing these events is important in further study. The consequences of cultural competence indicate three beneficiaries: clients, nurses, and healthcare organizations.

For **clients**, culturally competent care would improve health disparities among specific cultural groups [31,32]. The positive communication between nurses and clients can be obtained. Thus, the diagnosis and treatment of health problems are more culturally congruent with clients' situations. Positive communication increases satisfaction with quality of care and adherence to prescribed regimens [26,31]. Moreover, better health outcomes for clients were reported as symptoms and physiological and biochemical indices improved [33]. Through continuous cultural encounters, **nurses** also benefit from culturally competent care in terms of additional knowledge about diverse cultures. Nurses can develop from having cultural awareness to having cultural proficiency. They also gain the trust and respect from clients as they deliver these services to them, thereby facilitating a cooperative relationship and successful interaction with clients [5,26].

For **healthcare organizations**, having a culturally competent working team can provide effective healthcare services and therefore control the costs of care [5,34]. Providing culturally competent care may decrease malpractice claims, which is a crucial concern for healthcare organizations [34]. Hence, in developing cultural competence, dissemination of new knowledge inside an organization increases the efficiency of service and improves the quality of care, which advances the reputation of the whole team.

The following diagram shows the proposed relationships between essential attributes, antecedents and consequences for the concept cultural competence (Fig. 1).

3.8. Empirical referents

Empirical referents are “classes or categories of actual phenomena that by their existence or presence demonstrate the occurrence of the concept itself” (p. 73) [6]. Numerous empirical referents for the attributes of cultural awareness, cultural

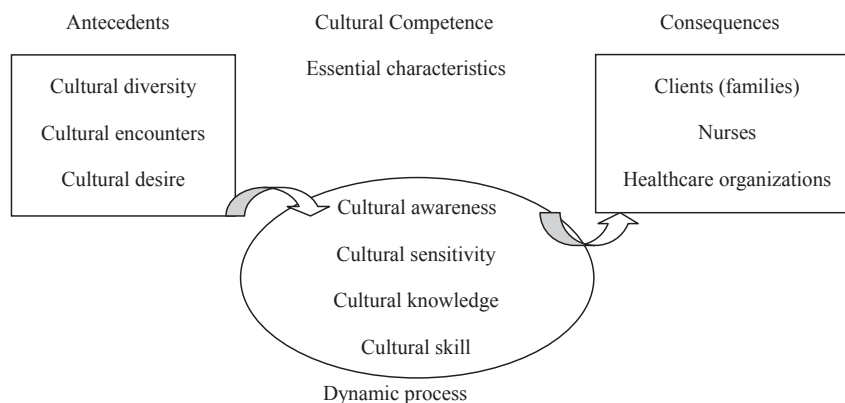


Fig. 1 – Cultural competence concept diagram.

sensitivity, cultural knowledge, cultural skill, and dynamic process were reported in the literature as items in the instruments that are primarily self-reported, such as the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals-Revised [24], Cultural Competence Assessment Instrument [35], and Nurse Cultural Competence Scale [4].

However, instruments that measure the concept from consumers' perspective or at the organizational level is rare, which should be discussed in future research. The analysis above indicates that clients and organizations are the beneficiaries of cultural competence, and organizations are responsible for cultural competence among nurses. Therefore, empirical referents should include other aspects aside from healthcare professionals' attitudes, knowledge, and behaviors. Clients' changes and organizations' performances should also be considered [36].

4. Implications for nursing research and practice

Based on this concept analysis, the definition of cultural competence for nurses emerges as the gradually developed capacity of nurses to provide safe and quality healthcare to clients with different cultural backgrounds. Cultural competence includes cultural awareness, sensitivity, knowledge, and skill. This definition can provide direction for future dialog, practice, and research in this area.

Since the end of the 20th century, the importance of developing culturally competent nurses has been gradually recognized. Researchers are encouraged to develop instruments for cultural competence evaluation and design interventions to improve the current nursing practice. However, consensus has not been achieved among researchers because of the ambiguity of the operational definition of this concept. This fact is evidenced by many cultural competence instruments that measure the different aspects of this concept [36]. A reliable and valid instrument that includes all the essential dimensions of cultural competence is needed to assess the entire nursing practice to determine directions for improvement. This analysis is helpful in evaluating existing instruments and constructing measuring tools.

Although related theoretical models can be used to understand cultural competence and guide the nursing practice, these models mainly focus on cultural assessments in nursing process, such as Leininger's Sunrise Model [1], Giger's Transcultural Assessment Model [9], and Purnell's Model for Cultural Competence [10]. Therefore, approaches to help nurses develop cultural competence during the entire nursing process with awareness, sensitivity, knowledge, and skill are not explicitly clarified. Campinha-Bacote contributed to the conceptual development of cultural competence; however, her model, which identifies the constructs of this concept, is inconsistent with other scholars in this area [18,25,37]. This analysis makes a compromise among scholars and researchers to achieve a more understandable description of cultural competence. A related framework may be generated to guide research interventions to improve cultural competence.

Another important issue identified through literature is the lack of strong empirical evidence about the effectiveness of culturally competent care [5]. Some of the questions that need to be examined are the following. How have clients been benefited? How does cultural competence relate to health disparities? How have health disparities been improved? Evidence-based practice always requires related research to be designed and conducted first based on a clear understanding of the concept. Both qualitative and quantitative methods can be applied to determine the correlations between cultural competence of nurses and client outcomes, health disparities, nurses' clinical performances, job satisfaction, and organizational achievement. For some eastern countries where cultural competence is not popularly addressed, further exploration of the concept should be encouraged because cultural diversity is ubiquitous inside healthcare systems.

Overall, this analysis highlights the need to reevaluate the works related to this concept and existing and new problems. In addition, this analysis can be used to develop a rigorous instrument or research design in the area of cultural competence.

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